

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained in our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a Burial Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
Crisfield		Lifetime		X Crisfield		RFD (Hopewell)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
RFD (Hopewell)									
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle LAWSON	Last BARNES, Sr.	4. DATE OF DEATH	Month June	Doy 24	Year 19 59	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 12, 1897	61 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Farming		Own farm		Maryland		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John Samuel Barnes		Mary Ann Cullen							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		217-12-4913		Mrs. Hilda Barnes, RFD Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Excitement due to burning							
434.4 Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	of his home, causing acute Sudden dilation of heart + death						
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Accidental fire in home							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Excitement							
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
Hour 4:00 p. m.	a. m. June 24 1959	While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	at work <input type="checkbox"/>	Home	Crisfield, Somerset, Md.				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion, death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
William H. Coulbourn, M. D.									
M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER									
DATE SIGNED 6/26/59									
ACTUAL SIGNATURE		William H. Coulbourn, M. D.							
EXAMINER'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)			
Burial		June 27, 1959		Sunnyridge Cemetery		Crisfield, Md.			
(State)		(State)		(State)		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Bradshaw & Sons, Crisfield, Md.				DATE JUN 29 '59		Arthur S. Kraus			
VS. A15ME									
5M 2/57									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File #243 6-15-59 et 07176

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD		d. STREET ADDRESS 1 100 S. 4TH STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILMORE	Middle WILMER	Last BOGGS	4. DATE OF DEATH JUNE 1 1959	Month JUNE	Day 1	Year 1959
5. SEX M	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1891	9. AGE (In years last birthday) 68 67 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY AUTO AGENCY		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES BOGGS				14. MOTHER'S MAIDEN NAME TILLIE CURTIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW1 217-03-7394		17. INFORMANT WILMER BOGGS		Address CRISFIELD, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. Death was caused by: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Arteriosclerosis (c) Cerebral Vascular Accident							
INTERVAL BETWEEN ONSET AND DEATH 1 day							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Calculus of Urinary Bladder, Cystitis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 6/1/59 to June 1, 1959					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20d. INJURY OCCURRED While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) CRISFIELD, Md.	(County)	(State)
21. I certify that I attended the deceased from June 1, 1959 to June 1, 1959 , that I last saw the deceased alive on June 1, 1959 , and that death occurred at 5:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, Md. DATE SIGNED 6/3/59							
ACTUAL SIGNATURE A. N. Barr							
PHYSICIAN'S NAME (Type) A. N. BARR, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 4, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Lawsonia Cemetery			22d. LOCATION (City, town, or county) Crisfield, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.				ADDRESS	24a. REC'D BY REGISTRAR JUN 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

BY SEPARATE STATEMENT OF THE STATE TO STATE CHARTER.

CHARTER OF STATE

1864-1877

1864
1867
1877

1864
1867

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7190

CERTIFICATE OF DEATH

Reg. Dist. No.

17177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield, Md.		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingston		d. STREET ADDRESS RFD		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edw. W. McCready Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First EDGAR	Middle FRANKLIN	Last BROUGHTON	4. DATE OF DEATH June 19 1959	Month June	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-1877		9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (tenant)		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Eugene Broughton		14. MOTHER'S MAIDEN NAME Octavia						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None 220-34-9898		17. INFORMANT Margie Broughton, Kingston, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 542x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Urinary Acute Disseminated Condition due to nephritis Chronic nephritis 70 days				INTERVAL BETWEEN ONSET AND DEATH 1 day		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Erectile Prostate Nodules						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Marion Station, Md.	(County)	(State)	
21. I certify that I attended the deceased from May 1, 1959, to June 19, 1959, and that death occurred at 3:20 P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE George C. Coulbourn	M.D.		Marion Station, Md.					
PHYSICIAN'S NAME (Type)	George C. Coulbourn, M.D.,		Marion Station, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 21, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Rehobeth Presbyterian		22d. LOCATION (City, town, or county) Rehobeth, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.	ADDRESS		24a. REC'D. BY REGISTRAR DATE JUN 24 '59		24b. REGISTRAR'S SIGNATURE C. L. Bradshaw			

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7191 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07178

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
7191		MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
		Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						d. LENGTH OF STAY IN lb		a. STATE		Maryland		b. COUNTY		Somerset	
Princess Anne, Md.															
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						X Princess Anne, Maryland		d. STREET ADDRESS						e. IS RESIDENCE ON A FARM?	
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Bertha		Middle Estelle		Lost		4. DATE OF DEATH		Month June		Day 11		Year 1959	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years at birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		October 31, 1887		71 yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife								Maryland				U. S. A.			
13. FATHER'S NAME								14. MOTHER'S MAIDEN NAME							
Edward Brittingham								Florence Butler							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No						Mr. Alton Dryden, Princess Anne, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia and Strangulation from Hanging INTERVAL BETWEEN ONSET AND DEATH Minutes															
974 X DUE TO															
Conditions, if any, which gave rise to immediate cause (b) Suicide															
(a), stating the underlying cause last. DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Light Cord around neck suspended from stairway post															
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
7;15 a.m. p.m.		6/11 1959		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Home		Princess Anne		Somerset		Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		<i>R. H. Johnson</i>													
EXAMINER'S NAME (Type)		R. H. Johnson													
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county)									
Burial June 14, 1959 at St. Andrew's						Princess Anne Md.									
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
James H. Johnson				DATE JUN 17 '59		Arthur S. Kraus									

REGULATORY STATE OF MICHIGAN - GRAND RAPIDS

REGULATORY STATE OF MICHIGAN - GRAND RAPIDS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REGULATORY STATE OF MICHIGAN - GRAND RAPIDS

First Name:	Last Name:
Address:	City:
State:	Zip:
Phone Number:	
Relationship to Deceased:	
Cause of Death:	
Date of Death:	
Time of Death:	
Place of Death:	
Signature:	

- Heart Disease
 Lung Disease
 Cancer
 Stroke
 Diabetes
 Arthritis
 Hypertension
 Kidney Disease
 Liver Disease
 Brain Disease
 Lung Disease
 Heart Disease
 Cancer
 Stroke
 Diabetes
 Arthritis
 Hypertension
 Kidney Disease
 Liver Disease
 Brain Disease

Signature:
Date:

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07179

7192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO. HOSP.		d. STREET ADDRESS 7 CROCKETT AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) NANCY		First	Middle	Last	4. DATE OF DEATH JUNE	Month	Day	Year
S. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JULY 31, 1881	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN WARD		14. MOTHER'S MAIDEN NAME AMELIA WARD				Address EVELYN GALE, 7 CROCKETT AVE, CRISFIELD, MD.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Consequence of Stroke - DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arteries closed		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Massachusetts , 19 ⁵⁹ , to Massachusetts , 19 ⁵⁹ , that I last saw the deceased alive on January 14, 1959 , and that death occurred at 518A M., from the causes and on the date stated above. ACTUAL SIGNATURE Sarah M. Peyton M.D. ADDRESS (Street, city or town, state) CRISFIELD, MD. DATE SIGNED June 18, 1959		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		22d. LOCATION (City, town, or county) Crisfield, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		ADDRESS		24a. REC'D BY REGISTRAR JUN 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

DEPARTMENT OF STATE - GENEVA - 6 APRIL 1947
CERTIFICATE OF DEATH

RECORDED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

19
2
20

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland b. COUNTY Somerset
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Allen	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Eden Box 27
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS /	

3. NAME OF DECEASED (Type or print)	(Fred Barkley) Frederick Alexander (Gunther)		Last	4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1YEAR	IF UNDER 24 HRS.	
male	colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 19, 1935	24 yrs.	Months	Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Alexander Barkley	14. MOTHER'S MAIDEN NAME Margart Gunther	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. (If yes, give war or date of service) war II	17. INFORMANT Mrs Margaret Barkley Eden, Md.
-------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------	--------------------------------------------------------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned	INTERVAL BETWEEN ONSET AND DEATH
1928.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)	DUE TO
	DUE TO
	(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-----------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was in swimming went under ad did not come up		
20c. TIME OF INJURY Month, Day, Year Hour 8 p.m. 6-30 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) New Allen	20f. (City or town) Allen Somerset Md	(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE R.H. Johnson	DATE SIGNED July 4-1959
--------------------------------------------	-----------------------------------

EXAMINER'S NAME (Type) R.H. Johnson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
--------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------

22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 7-5-59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Flower Hill	22d. LOCATION (City, town, or county) Eden, Maryland	(State)
---------------------------------------------------------------	------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------------	---------

23. FUNERAL DIRECTOR'S SIGNATURE Severn R. Wilson	24a. REC'D BY REGISTRAR Princess Anne, Md.	DATE JUL 7 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause
-------------------------------------------------------------	------------------------------------------------------	----------------	-------------------------------------------------------

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10. The following table shows the number of hours worked by 1000 employees in a company.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7194

CERTIFICATE OF DEATH

07181

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Md		c. LENGTH OF STAY IN lb LIFE TIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Princess Anne, Md					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Edward	Middle S	Last Handy	4. DATE OF DEATH	Month 6/8	Day 19	Year 59	
S. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/25/1894	9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months 0	DAYS 0	IF UNDER 24 HRS. Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY Privert Family		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A.			
13. FATHER'S NAME Isaac Handy				14. MOTHER'S MAIDEN NAME Adeline ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. I93-03-1982		17. INFORMANT Robert Handy		Address Princess Anne, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Haemorrhage DUE TO (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH 1 day 6 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 14		20f. (City or town) Princess Anne, Md		(County) Princess Anne, Md	(State) Md
21. I certify that I attended the deceased from Nov 10th, 1958 to June 8th, 1959 , that I last saw the deceased alive on June 8th, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Princess Anne, Md.									
ACTUAL SIGNATURE Gordon G. McNamee									
PHYSICIAN'S NAME (Type) John Wesley									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/59		22c. NAME OF CEMETERY OR CREMATORIAL John Wesley		22d. LOCATION (City, town, or county) Princess Anne, Md			
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr					ADDRESS Princess Anne, Md		24a. REC'D BY REGISTRAR JUN 15 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7195

CERTIFICATE OF DEATH

07182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TYLERSTON		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. MCCREADY MEMORIAL HOSP.			e. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) eva evans hoffman			4. DATE OF DEATH Month JUNE Day 28 Year 19 59		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JAN 17, 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ALEC EVANS			14. MOTHER'S MAIDEN NAME ADELIA BRADSHAW		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT WILLIAM HOFFMAN	Address TYLERSTON, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH 2 hr.		
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			DUE TO (b) Cardiac decompensation DUE TO (c) Arterio sclerotic heart disease Months years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield	(County) Wicomico (State) Md.
21. I certify that I attended the deceased from JUNE 28 , 19 59 , that I last saw the deceased alive on JUNE 28TH , 19 59 , and that death occurred at 4:55 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE C.G. Rawley		ADDRESS (Street, city or town, state) Main Street, Crisfield, Md. DATE SIGNED Rawley			
PHYSICIAN'S NAME (Type) C.G. Rawley, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Tylerston ME Cemetery	22d. LOCATION (City, town, or county) Tylerston, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.			ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Rawley

BY COMMITTEE ON THE STATE QUALIFICATION

CHART TO DRAW

NAME	AGE	SEX	STATE	QUALIFICATION	EXEMPTIONS	NOTES
John Smith	35	M	Mass.	18 years	None	
Jane Doe	28	F	Conn.	18 years	None	
Samuel Johnson	42	M	N.Y.	18 years	None	
Elizabeth Williams	30	F	R.I.	18 years	None	
Robert Green	50	M	Vt.	18 years	None	
Mary Brown	25	F	P.R.	18 years	None	
William Davis	38	M	Calif.	18 years	None	
Anna Lee	22	F	Tenn.	18 years	None	
George Washington	45	M	Pa.	18 years	None	
Susan Moore	20	F	Miss.	18 years	None	
James Clark	32	M	Ind.	18 years	None	
Sarah Jackson	27	F	Ala.	18 years	None	
John Taylor	37	M	Tex.	18 years	None	
Mary Parker	24	F	Okla.	18 years	None	
James Moore	34	M	Kan.	18 years	None	
Susan Clark	21	F	Colo.	18 years	None	
John Jackson	31	M	N.M.	18 years	None	
Mary Moore	23	F	Ariz.	18 years	None	
James Parker	30	M	Utah	18 years	None	
Susan Clark	22	F	Mont.	18 years	None	
John Jackson	29	M	Wyo.	18 years	None	
Mary Moore	21	F	Idaho	18 years	None	
James Parker	28	M	Wyoming	18 years	None	
Susan Clark	20	F	Montana	18 years	None	
John Jackson	27	M	North Dak.	18 years	None	
Mary Moore	19	F	South Dak.	18 years	None	
James Parker	26	M	Nebraska	18 years	None	
Susan Clark	18	F	Wyoming	18 years	None	
John Jackson	25	M	North Dakota	18 years	None	
Mary Moore	17	F	South Dakota	18 years	None	
James Parker	24	M	Montana	18 years	None	
Susan Clark	16	F	Wyoming	18 years	None	
John Jackson	23	M	North Dakota	18 years	None	
Mary Moore	15	F	South Dakota	18 years	None	
James Parker	22	M	Montana	18 years	None	
Susan Clark	14	F	Wyoming	18 years	None	
John Jackson	21	M	North Dakota	18 years	None	
Mary Moore	13	F	South Dakota	18 years	None	
James Parker	20	M	Montana	18 years	None	
Susan Clark	12	F	Wyoming	18 years	None	
John Jackson	19	M	North Dakota	18 years	None	
Mary Moore	11	F	South Dakota	18 years	None	
James Parker	18	M	Montana	18 years	None	
Susan Clark	10	F	Wyoming	18 years	None	
John Jackson	17	M	North Dakota	18 years	None	
Mary Moore	9	F	South Dakota	18 years	None	
James Parker	16	M	Montana	18 years	None	
Susan Clark	8	F	Wyoming	18 years	None	
John Jackson	15	M	North Dakota	18 years	None	
Mary Moore	7	F	South Dakota	18 years	None	
James Parker	14	M	Montana	18 years	None	
Susan Clark	6	F	Wyoming	18 years	None	
John Jackson	13	M	North Dakota	18 years	None	
Mary Moore	5	F	South Dakota	18 years	None	
James Parker	12	M	Montana	18 years	None	
Susan Clark	4	F	Wyoming	18 years	None	
John Jackson	11	M	North Dakota	18 years	None	
Mary Moore	3	F	South Dakota	18 years	None	
James Parker	10	M	Montana	18 years	None	
Susan Clark	2	F	Wyoming	18 years	None	
John Jackson	9	M	North Dakota	18 years	None	
Mary Moore	1	F	South Dakota	18 years	None	
James Parker	8	M	Montana	18 years	None	
Susan Clark	7	F	Wyoming	18 years	None	
John Jackson	6	M	North Dakota	18 years	None	
Mary Moore	5	F	South Dakota	18 years	None	
James Parker	4	M	Montana	18 years	None	
Susan Clark	3	F	Wyoming	18 years	None	
John Jackson	2	M	North Dakota	18 years	None	
Mary Moore	1	F	South Dakota	18 years	None	
James Parker	0	M	Montana	18 years	None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7186

117183

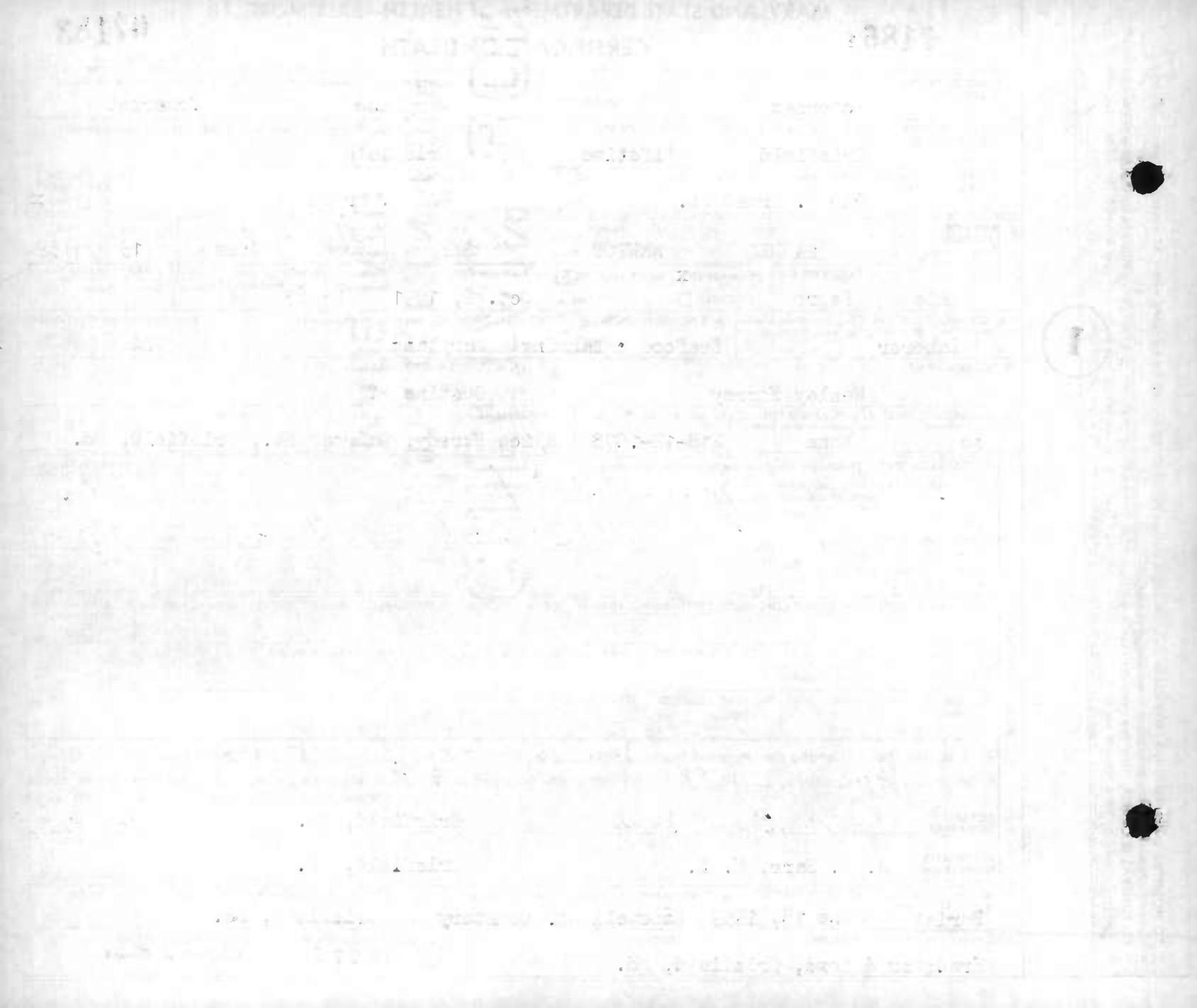
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 946 W. Broad St.		d. STREET ADDRESS 946 W. Broad St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SAMUEL		First NEWTON	Middle HORSEY	4. DATE OF DEATH Month June	Day 15	Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 8, 1891	9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood & Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Horsey				14. MOTHER'S MAIDEN NAME Gustine ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-1078		INFORMANT Alice Horsey, 9 Broad St., Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 2 days							
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerotic Heart Disease & Decongestion		DUE TO (c)		5 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 0		20f. (City or town) (County) (State) 0	
21. I certify that I attended the deceased from Mar. 16, 1959 , to June 15, 1959 , that I last saw the deceased alive on June 15, 1959 , and that death occurred at 9 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE A. N. Barr, M.D. ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 6/19/59							
PHYSICIAN'S NAME (Type) A. N. Barr, M. D.		Crisfield, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Hopewell AME Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
						24b. REGISTRAR'S SIGNATURE Charles S. Finch	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117184

7195

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount		c. LENGTH OF STAY IN 1b 1 year		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount		e. IS RESIDENCE ON A FARM? YES NO	
d. NAME OF HOSPITAL (If not in hospital, give street address) Harris Nursing home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First Henry	Middle	Last Moore	4. DATE OF DEATH Month 6	Day 18	Year 1959
5. SEX		6. COLOR OR RACE Male Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 1884	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Saw Mill			
11. BIRTHPLACE (State or foreign country) Delaware				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Moore				14. MOTHER'S MAIDEN NAME Engline ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT Somerset County Welfair, Princess Anne, Md			
Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500.1 DUE TO Acute Bronchitis INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Colic							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic General Arthritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 10, 1958 , to June 18, 1959 , that I last saw the deceased alive on June 16, 1959 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Princess Anne, Maryland DATE SIGNED ACTUAL SIGNATURE Eldon G. Markman M.D. Princess Anne, Maryland							
PHYSICIAN'S NAME (Type) Eldon G. Markman				Princess Anne, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/59		22c. NAME OF CEMETERY OR CREMATORIUM Zion		22d. LOCATION (City, town, or county) (State) Laurel, Delaware.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
						24b. REGISTRAR'S SIGNATURE Charles J. Thrua	

25

D 222

Anne, Mrs. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07185

7197

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>SOMERSGT</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WENONA</u>		c. LENGTH OF STAY IN lb <u>LIFETIME</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WENONA</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HER HOME</u>		d. STREET ADDRESS <u>1 MAIN ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ELLA</u>		First	Middle	Last	4. DATE OF DEATH <u>JUNE 11 1959</u>	Month	Day	Year
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 2 - 1907</u>	9. AGE (In years lost birthday) <u>52</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEHOLD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>2/SA</u>		
13. FATHER'S NAME <u>DAVID WHITE</u>		14. MOTHER'S MAIDEN NAME <u>MARY TAYLOR</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ROBERTA PARKINSON - WENONA MD</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>422.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) _____ DUE TO _____ (c) _____								
INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
<u>Chronic Osteo-Arthritis</u>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
MEDICAL CERTIFICATION								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Princess Anne</u>						
20c. TIME OF INJURY	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>WENONA</u>	20f. (City or town) (County) (State)		
Hour o. m. p. m.			19					
21. I certify that I attended the deceased from <u>May 15 1955</u> to <u>June 11 1959</u> , that I last saw the deceased alive on <u>June 10 1959</u> , and that death occurred on <u>June 11 1959</u> M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <u>Eldon G. M. Manton</u>								
DATE SIGNED <u>6-15-59</u>								
ACTUAL SIGNATURE <u>Eldon G. M. Manton</u>								
PHYSICIAN'S NAME (Type) <u>Princess Anne</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-14-59</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>ST. PAUL'S</u>		22d. LOCATION (City, town, or county) <u>WENONA</u> (State) <u>MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Z. S. Webster Seal J. Farland</u>								
ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Anna</u>				

STATE OF GEORGIA
GENERAL STATE BOARD OF EDUCATION - BOARDING

CERTIFICATE OF DEATH

RECEIVED

RECEIVED

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07186

7187

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 S. 4th Street		d. STREET ADDRESS 126 S. 4th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CLIFTON		First	Middle	Last	4. DATE OF DEATH JUNE 9, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 4, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Doys	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Taylor			14. MOTHER'S MAIDEN NAME Lear Wilson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 214-03-7543A		INFORMANT Charles Taylor, Paper St., Crisfield, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) abdominal tumor (Type?) DUE TO 239X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Removed in H. Howard Hospital DUE TO 1958 - (c)								
INTERVAL BETWEEN ONSET AND DEATH 1 yr -								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 7, 1959 , to June 9, 1959 that I last saw the deceased alive on June 9, 1959 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 33 W. Main						
ACTUAL SIGNATURE Sarah M. Peyton, M. D.		DATE SIGNED 6/13/59						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Marumsco AME Cemetery		22d. LOCATION (City, town, or county) (State) Marumsco, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arnold S. Krause		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07187

7198

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEAL ISLAND		c. LENGTH OF STAY IN lb All his life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 165		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward L. Wallace		First	Middle
4. DATE OF DEATH 6 13 1959	Month	Day	Year
5. SEX M	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1893
9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEA food	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC WALLACE		14. MOTHER'S MAIDEN NAME MARY Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 231-10-1518	
17. INFORMANT Mrs. LENA WALLACE, DEAL ISLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		19 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 442 X		years	
DUE TO (b)		Hypertensive cardiovascular disease	
DUE TO (c)		Arterionephrosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-25-59 , 19, to 6-13-59 , 19, that I last saw the deceased alive on 6-13-59 , 19, and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Everett C. Sutter		ADDRESS (Street, city or town, state) Dames Quarter, Maryland	
PHYSICIAN'S NAME (Type) Everett C. Sutter MD		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6-17-59		22b. DATE THEREOF John Wesley Cem	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS J. F. Stewart Fun. Home, Salisbury, Md.		22d. LOCATION (City, town, or county) DEAL ISLAND, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Fun. Home, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE JUN 23 '59	
		24b. REGISTRAR'S SIGNATURE Arthur & Krause	

CERTIFICATE OF DEATH

STATE OF DELAWARE - CITY OF WILMINGTON - DECEMBER 18

DEATH CERTIFICATE

X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17188

7199

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHANCE		c. LENGTH OF STAY IN 1b LIFETIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHANCE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HER HOME		d. STREET ADDRESS 1 MAIN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELLA	Middle	Last WATERS	4. DATE OF DEATH Month JUNE	Day 3	Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUG. 1 - 1896	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 62		IF UNDER 24 HRS. Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEHOLD DUTIES		10b. KIND OF BUSINESS OR INDUSTRY HOUSEHOLD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB		14. MOTHER'S MÄDEN NAME PRICE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. -	
17. INFORMANT MATTHEW WATERS-		Address CHANCE MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastricoma Uterus		INTERVAL BETWEEN ONSET AND DEATH 5 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 174X		DUE TO (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		Month Sept	Day 19	Year 1954	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 10th	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CHANCE	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1954 to June 3rd , 1959, that I last saw the deceased alive on June 2nd , 1959, and that death occurred at CHANCE on June 3rd , 1959, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Princess Anne, Md.							
DATE SIGNED 6/15/59							
ACTUAL SIGNATURE Eldon G. Matheson		PHYSICIAN'S NAME (Type) Eldon G. Matheson					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 7-1959		22b. DATE THEREOF June 7-1959		22c. NAME OF CEMETERY OR CREMATORIUM ST. CHARLES METHODIST		22d. LOCATION (City, town, or county) CHANCE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE L.S. Webster		ADDRESS Princess Anne		24a. REC'D BY REGISTRAR Dad		24b. REGISTRAR'S SIGNATURE Cathleen K. Keenan	
VS A15 (4) 15M 10/57		DATE JUN 9 '59					

CEMETERY OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

107189

7200

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
Somerset MARYLAND				Maryland Somerset					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Pocomoke				X Pocomoke					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS					
Home				R.F.D. #1					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Rosie			Della	Waters	June	9	1959		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Apr. 3, 1881	78 yrs.	Months	Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Domestic		House Work		Virginia		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
John Long				Louise ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			Address
No				None		Hedstrom Waters R.F.D. #1			Poconos City, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									2 yrs.
331X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)									5-6 yrs.
DUE TO									
(c) Essential Hypertension									5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Electrolyte imbalance									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19									
21. I certify that I attended the deceased from 5/16/1959 to 6/9/1959, that I last saw the deceased alive on 6/9/1959, and that death occurred at 1:45 PM from the causes and on the date stated above.									ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE Cecil A. Duverney, M.D.									DATE SIGNED 801-4 th St, Pocomoke, Md.
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Burial				6-14-59		Unionville Cem.		Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Zagorski & Sons				Chesapeake Meyer		DAUN 17 '59		Arthur & Maria	

MISSOURI STATE DEPARTMENT OF AGED - DEATH CERTIFICATE

CERTIFICATE OF DEATH

BORN

7201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 78 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		d. STREET ADDRESS JOHNSONCREEK RD.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO. HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First ANNE	Middle	Last WILSON	4. DATE OF DEATH JUNE 24 1959	Month Day Year		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-14-1880	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN H. LAWSON		14. MOTHER'S MAIDEN NAME NANCY STERLING						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
				MARTHA NELSON, CRISFIELD, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) Hemiplegia, etc. 5 days								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) CRISFIELD	(County) MD.	(State) MD.
21. I certify that I attended the deceased from June 19, 1959 , to June 24, 1959 , that I last saw the deceased alive on June 24, 1959 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
ACTUAL SIGNATURE <i>C. G. Rawley</i>	M.D.		DATE SIGNED 6-24-59		CRISFIELD, MD.			
PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D., CRISFIELD, MARYLAND								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JUNE 27-1959	22c. NAME OF CEMETERY OR CREMATORIAL ASBURY METHODIST		22d. LOCATION (City, town, or county) CRISFIELD		(State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>L.B. Webster</i>		ADDRESS Crisfield Md.		24a. REC'D BY REGISTRAR JUL 1 '59	24b. REGISTRAR'S SIGNATURE <i>Chas. S. Trahan</i>			

